

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

REG 20715039

SL 21220

7789 - 61 - 031035  
STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

FILED AUG 28 1961 318

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>ILLINOIS</u> b. COUNTY |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>ST. LOUIS, MO.</u>                |  | Length of stay in 1b<br><u>8 DAYS</u>   | c. CITY OR TOWN <u>CASEYVILLE</u>                                   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>VAH, ST. LOUIS, MO.</u> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><u>15 PASADENA</u> |
| Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                     |  |   |   |

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|--|--|--|---|--|
| 3. NAME OF DECEASED (Type or print)<br>First <u>ELMER</u> Middle <u>C</u> Last <u>PFEIFFER</u> |  |  | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>19</u> Year <u>1961</u> |  |
|--|--|--|---|--|

|                       |                                  |   |                                    |                                     |  |  |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|--|
| 5. SEX<br><u>MALE</u> | 6. COLOR OR RACE<br><u>WHITE</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4/18/93</u> | 9. AGE (last birthday)<br><u>68</u> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|--|

|   |                                   |   |  |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>JANITOR</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><u>EAST ST. LOUIS, ILL.</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u> |
|---|-----------------------------------|---|--|

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|--|---|---|
| 13a. FATHER'S NAME<br><u>HENERY PFEIFFER</u> | 13b. MOTHER'S MAIDEN NAME<br><u>MARIE DROZA</u> | 14. NAME OF HUSBAND OR WIFE<br><u>EDNA PFEIFFER</u> |
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|   |   |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>YES WW I</u> | 17. INFORMANT Address<br><u>Edna Pfeiffer (WIDOW) SEE # 2</u> |
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|  |  |                                  |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a)  | <u>THROMBOSIS, RT COMMON ILIAC ARTERY WITH EXTENSION TO DISTAL AORTA</u> | <u>12 HRS</u>                    |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.               | DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>                           | <u>20 YRS</u>                    |
|  | DUE TO (c) <u>4500</u>   |                                  |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>POST OPERATIVE LEFT ABOVE KNEE AMPUTATION</u> | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
|---|---|--|

|   |  |  |                              |        |       |
|---|--|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____<br>a.m. _____ p.m. _____ | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE |
|---|--|--|------------------------------|--------|-------|

21. VA attended the deceased from 8/11/61 to 8/19/61 and last saw him alive on 8/19/61  
Death occurred at 9:50 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

|   |  |                                    |
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| 22a. SIGNATURE<br><u>R. E. McBERT</u> (Degree or title) | 22b. ADDRESS<br><u>VAH, ST. LOUIS, MO.</u> | 22c. DATE SIGNED<br><u>8/20/61</u> |
|---|--|------------------------------------|

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE<br><u>Aug. 23, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Val Halla Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Belleville Illinois</u> |
|---|-----------------------------------|---|---|

|  |                                      |  |   |
|--|--------------------------------------|--|---|
| 24. FUNERAL DIRECTOR<br><u>P.W. Schildknecht</u> | ADDRESS<br><u>O'Fallon, Illinois</u> | 25. DATE RECD. BY LOCAL REG.<br><u>AUG 22 1961</u> | 26. REGISTRAR'S SIGNATURE<br><u>Earl Smith M.D.</u> |
|--|--------------------------------------|--|---|

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was <sup>not</sup> embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed P. H. Schildknecht

Licensed Embalmer No. Ill. 8549

P. O. Address D'Fallon, Illinois

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.